

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-029857

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 374

Primary Registration District No. 4547

Registrar's No. 17

FILED JUL 24 1962

VS 300
Rev. 4/59

1 1130

2 1130

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12 90-0

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Worth County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grant City</u>		c. CITY OR TOWN <u>Worth</u>	
Length of stay in lb <u>3-month's</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 East Lovers Lane</u>		d. STREET ADDRESS (If outside, give location) <u>I mile north-west</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>J.</u> Last <u>Cain</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	
13a. FATHER'S NAME <u>James Cain</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Early</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT Address <u>O Faye Cain Grant City Missouri</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			
20c. TIME OF INJURY Hour <u>8:30</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Month, Day, Year <u>7-4-62</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <u>Grant City</u>		COUNTY <u>Mo</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>1968</u> to <u>7-4-62</u> and last saw him alive on <u>7/5/62</u>			
Death occurred at <u>8:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree Co. 1119) <u>Frank B Matteson M D</u>		22b. ADDRESS <u>Grant City, Mo</u>	
22c. DATE SIGNED <u>7/5/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July-6-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Grant City Missouri</u>	
24. FUNERAL DIRECTOR <u>John Andrews</u>		ADDRESS <u>Grant City Missouri</u>	
25. DATE RECD. BY LOCAL REG. <u>7-17-1962</u>		26. REGISTRAR'S SIGNATURE <u>Letta E. Dawson</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me,
or by John Andrews, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Andrews

Licensed Embalmer No. 4211

P. O. Address Grant City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.